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before the
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Oversight Hearing on "The National Synthetic Drug Control Strategy"
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Chairman Souder, Ranking Member Cummings, members of the Committee, and staff, thank you for this opportunity to appear before you today on behalf of the National Alliance for Model State Drug Laws (NAMDSL) to offer my perspective on the recently released ***Synthetic Drug Control Strategy*** as it relates to states' legislative efforts to address methamphetamine (meth), the corollary issues of meth, states' work to establish prescription drug monitoring programs (PDMPs) as tools to assist in addressing the nonmedical use of prescription drugs, and the expressed needs of states as shared with me and the NAMSDL staff in our work with states on these and other alcohol and other drug related legislative and policy issues. I am honored to be here to discuss these issues and to respond to any questions that you may have.

About the National Alliance for Model State Drug Laws

As you may know, the National Alliance for Model State Drug Laws (NAMSDL) is the successor of the President's Commission on Model State Drug Laws, appointed by President George H. W. Bush. At the conclusion of the Commission's work of crafting the 44 model state drug laws addressing over 70 alcohol and other drug issues, the Commissioners created a 501(c)(3) nonprofit organization to serve as an ongoing, bipartisan, independently operated resource to assist states in assessing needs, strategizing, and implementing laws and policies to address alcohol and other drug problems using the model laws as a menu of options. Congress began funding NAMSDL in fiscal year 1995 to hold state model drug laws summits to serve as needs assessment and action planning mechanisms and to provide technical assistance to states as they implement summit recommendations including elements of the models and address emerging issues related to alcohol and other drugs. NAMSDL's Congressional appropriations also allow the organization to provide technical assistance to states as they consider legislative and policy priorities related to alcohol and other drugs, including drafting, feedback on bills, regional analysis, and collections of existing statutes from other states.

In 2003, NAMSDL accepted a grant from the Office of Justice Programs (OJP), Bureau of Justice Assistance (BJA) to serve as the technical assistance provider for states under the Harold Rogers Prescription Drug Monitoring Program, a competitive grant program currently administered by BJA to assist states in their efforts to plan, establish, and enhance prescription drug monitoring programs (PDMPs). While this is an issue on which NAMSDL has assisted states since the organization's inception, this dedicated

funding allows NAMSDL to provide states with more intensive assistance and to coordinate information related to these programs.

NAMSDL's Work with States to Address Meth and Its Related Issues, Nonmedical Use of Prescription Drugs

During the past two years, requests for information and assistance coming into NAMSDL have been overwhelmingly focused on meth and its related issues. While other alcohol and other drug-related technical assistance requests were received and fulfilled by NAMSDL, meth was by far the highest legislative priority in the substance abuse arena for states. Requests for assistance with meth-related legislation reached such a volume at NAMSDL that the organization has convened two national methamphetamine legislative and policy conferences (2004 and 2005) in an effort to most efficiently and effectively address and accommodate the needs of states in this arena. Since the inception of NAMSDL in 1993, I have rarely seen – without a federal mandate or funding incentive – this number of states pursue legislation simultaneously to address a drug-related issue as occurred regarding methamphetamine.

A clear yet not distant runner-up to meth among the issues on which NAMSDL assisted states was prescription drug diversion, misuse, abuse, and addiction - specifically states' efforts to establish PDMPs as tools to assist in addressing the nonmedical use of these controlled substances. Under the aforementioned grant from BJA, NAMSDL has convened three national conferences on PMPs (2003, 2004, 2006) to provide legislative and programmatic information to states to facilitate the implementation and enhancement of these programs.

A number of state officials and those working with them to draft legislation to address meth and its related issues and PDMPs have indicated that NAMSDL is ***the*** resource nationally on which they rely for assistance in these areas, including sample statutory language, feedback on draft bills, and synthesis of legislative efforts nationwide and/or in their region. It is from NAMSDL's perspective in working with states in these capacities and in volume that I offer the following observations regarding states' efforts to address meth and prescription drugs as well as related thoughts regarding the strategy. Where I discuss points of concern regarding the strategy, I offer this feedback with the hope that these issues may be incorporated into the agencies' plans as they work with, partner with, share with, encourage and support state and local efforts as they note as their intent through the strategy.

States have led the way re: legislation to address access to precursor chemicals for meth

I appreciate the strategy's recognition of the states' leadership in enacting measures to restrict over-the-counter (OTC) purchases and sales of pseudoephedrine products. As the document also acknowledges, states' efforts to control access to precursor chemicals for meth by regulating sales of OTC pseudoephedrine products appear to have resulted in a reduction in the number of domestic small toxic labs as well as an apparent decline in the

percentage of available meth that is produced by these domestic labs. To date, forty-two states have some measure in place to restrict access to pseudoephedrine products while safeguarding their use for licit purposes. States' legislative efforts to address the purchases of products containing pseudoephedrine reflect four general categories of restrictions: 1) restrictions on the display or offer of the product for sale – including but not limited to scheduling pseudoephedrine, 2) restrictions on who can sell/transfer and/or who can purchase the products, and the requirement to maintain a log/record of the transaction, 3) restrictions on the quantity of a product that can be sold/transferred or purchased within a specified timeframe, and 4) restrictions on packaging of the products. These legislative/regulatory efforts often include exemptions/exceptions to restrictions on the over-the-counter sales/transfer or purchases of pseudoephedrine products in an effort to balance, as the strategy suggests, "law enforcement needs with the need for legitimate consumer access to cold remedies" (p. 22). An overview prepared by NAMSDL of states' efforts to address pseudoephedrine products has been submitted with my testimony for the record.

States are likely to be interested in the outcomes of the National Institute of Justice's (NIJ) 18-month study of the effectiveness of states' restrictions on pseudoephedrine products that the strategy describes, as the results could assist in efforts to refine their existing legislation. However, this information may not necessarily be the most germane to states' new legislative needs as they are now prioritizing the implementation of additional restrictions on the supply of pseudoephedrine and other precursors in their states, such as considering wholesale and manufacturing provisions. With approximately 80% of states having some measure to address pseudoephedrine in place, states may not necessarily need the Administration's assistance legislatively on the issue of access to OTC pseudoephedrine products.

The strategy fails to specifically acknowledge the range of legislative initiatives that states are using to monitor the flow of precursor chemicals to prevent diversion for the illegal manufacture of methamphetamine. OTC restrictions are only one type of measure that states are developing to trace chemicals at the retail, wholesale and manufacturing levels. For example, states have enacted registration requirements for wholesalers. Washington has gone one step further and limited the quantity of pseudoephedrine products that wholesalers may sell if the total monthly sales of the products within that state exceed a specific percentage of the total prior monthly sales of nonprescription drugs to persons within the state. Legislative efforts such as these have likely contributed to the decrease in domestic meth labs, yet will likely not be part of the outcomes study described in the strategy. Further, these initiatives have not yet been acknowledged or encouraged by the relevant Administration agencies.

Additionally, states have needed to tailor restrictions to meet the specific issues they were experiencing related to meth. For example, Maine enacted restrictions on pseudoephedrine products in an effort to prevent domestic meth labs from becoming a significant problem in the state. Therefore, the national study may or may not find the state's legislation to be as "effective" as other states given the parameters set in the study. However, Maine's law may meet the intended goal and need that the state had in

pursuing the legislation. While the NIJ study will be of interest, it will likely not reflect the overall success of states' efforts.

The strategy references states' efforts to establish tracking systems for OTC purchases and sales of pseudoephedrine products. However, states will struggle to implement these given the ongoing funding challenges, including cuts proposed in the President's Fiscal Year 2007 budget. A commitment of resources to support these touted efforts by states is needed for them to be realized.

States were able to enact these measures to address meth's precursors without 1) the benefit of the Office of National Drug Control Policy (ONDCP) officials testifying to the national priority on meth-related problems – as they have on other substance abuse issues in the states, 2) national data - save for meth lab incident numbers from the El Paso Intelligence Center (EPIC), which, as the strategy alludes, are often not a complete picture, leaving states to rely on their own data collection, or 3) a stable understanding of funding available to support corollary efforts related to meth given the Administration's recent budget proposals that offered reductions and eliminations to funding sources for state and local drug efforts. Based on states' success with these legislative efforts absent Administration support, it is unclear from the strategy how its future involvement may be relevant.

Cleanup and Remediation of Former Meth Lab Sites

From this strategy, the Administration agencies now appear to recognize that the federal government should undertake research to develop and support health-based guidelines for remediating meth labs. This is a need that the Congress acknowledged through the House's passage of HR798 and the Senate's current consideration of S2019. States, once again, are also leaders in this arena. Through legislation and regulation, a growing number of states are addressing the cleanup and remediation of former meth lab sites, given these sites were increasingly residential (e.g. houses, apartments, mobile homes, and other habitable sites). An overview prepared by NAMSDL of states' legislative/regulatory efforts in this area has been submitted with my testimony for the record.

States are addressing issues such as the regulation of cleanup and remediation contractors, notice to potential buyers of former meth lab properties, and supplemental funding for the cleanup and remediation of these sites. Thirteen states have established decontamination standards for meth lab cleanup and remediation. These standards are feasibility-based rather than health-based, which many acknowledge would be the ideal. However, the current lack of research into the short and long term effects related to the production of meth precludes setting health-based standards. Many states are utilizing the regulation and guideline process rather than legislation to address cleanup and remediation, as these measures are more easily changed to match emerging science should research in this area expand. The strategy acknowledges the need for this research and the subsequent development of cleanup and remediation standards based on scientific findings. Toward that end, the strategy's discussion of cleanup and remediation echoes

HR 798 and S2019. States concur with this need for additional research and applaud Congress' pursuit of it this session.

Despite recognizing the importance of addressing cleanup and remediation needs, the strategy lacks specific steps to proactively provide state and local policymakers with relevant information on cleanup and remediation issues for their current work, such as existing applicable research and its policy implications, and existing options for funding cleanup and remediation. States need this type of tangible information to support their existing and ongoing efforts.

Multidisciplinary Coordination of Drug Endangered Children Efforts

Efforts to address drug endangered children (DEC) remain high among states' legislative and policy priorities. States' legislative efforts to address DEC have largely fallen into three categories: 1) increasing penalties for certain activities which occur in the presence of children, 2) increasing penalties but also defining prohibited activity as child endangerment, neglect, or abuse, and 3) emergency or exigent circumstances, e.g. if a responder can immediately remove child from a lab without first obtaining a court order and take child to child protection services or other safe location. An overview prepared by NAMSDL of states' efforts to address DEC issues has been submitted with my testimony for the record.

From a policy and practice standpoint, states are working to coordinate agencies' services that are relevant to children's safety and welfare as they are found at meth lab sites and/or in drug effected homes, such as law enforcement, medical services, child protective services, and social services. Training is an important component of best serving the needs of these children, as the strategy indicates; this must be provided across a range of disciplines and services then coordinated among the relevant state agencies. While initial federal resources addressing DEC were made available for and through law enforcement, states acknowledge that this is a multidisciplinary problem needing coordinated, multidisciplinary responses.

States' Focus on Prevention and Treatment Options

While I am encouraged that the strategy includes prevention and treatment as part of its scope, I am concerned that the commitments made by the agencies will not meet the states' current level of focus on demand reduction. With states' domestic meth lab numbers currently on the decline, state officials and decision makers have prevention and treatment options high among their legislative and policy priorities. NAMSDL has experienced a notable increase in states' requests for this type of assistance. Additionally, meth presents an interesting prevention scenario, given that the demographic with the highest rates of meth use is older, not the youth to whom most prevention programming is directed. While the strategy acknowledges this demographic and also understandably focuses on efforts to prevent meth use among youth, it does not commit to action or offer to states assistance in addressing the adult, working population that is vulnerable to meth use. Further, the strategy does not describe specific prevention

options available to states, including replicable programs touted by Administration officials, such as the Oregon Partnership and the Montana Meth Project.

A growing number of states are using the predominance of meth-related efforts as an opportunity to examine and expand - as resources allow - its addiction treatment services. Historically due to high demand and less than adequate funding, states have not been able to meet the needs for addiction treatment. Waiting lists are a long standing reality. While the strategy indicates support for treatment, it does not clearly acknowledge the need to expand treatment resources. For example, the strategy references the President's request for "a significant increase in support to states for drug courts" (p. 26), which are useful mechanisms for getting individuals assess for and referred to addiction treatment. However, drug courts are not, in and of themselves, drug treatment and are often as effective as the addiction treatment options to which their participants are referred. Therefore, there remains an inferred gap between needs and resources in the strategy.

Given the unmet treatment needs in states throughout the country, addiction treatment clinicians have also indicated to NAMSDL that while ongoing research into effectiveness of protocols is important to providing the best services possible, they cautious against, if you will, "robbing Peter to pay Paul." Meth is not a new drug and is not new to addiction treatment professionals. The field has been successfully treating individuals addicted to drugs including meth for over 30 years when meth arguably first emerged as "crank." While additional research regarding effectiveness is unquestionably beneficial, there is concern that critical dollars are being spent to research some of what is already known in the field – if meth addiction can be treated and how – rather than spent to provide additional direct services to those presenting for treatment. The emphasis of the strategy's treatment portion provides reason to remain concerned about this allocation of federal resources.

Further, the strategy does not include specific proactive steps to provide state and local policymakers with accurate information about existing options for treating of methamphetamine addiction and the success of these modalities. The strategy acknowledges that there is a "common misperception that methamphetamine addiction is so addictive that it is impossible to treat" (p. 26). However, there is no discussion of what the relevant Administration agencies intend to do toward correcting this "common misperception." Based on NAMSDL's work with states, I can tell you that a number of the individuals who have this "common misperception" are state legislators and other decision makers who are charged with making funding, policy and programmatic decisions. While ongoing research related to needed improvements in addiction treatment is always beneficial, it is also important to provide current decision makers with accurate information about addiction treatment and its effectiveness upon which they can base resource allocation and other policy decisions.

States Need for Relevant Data, Meth-Related Information from a Central Resource

In working with states during the past two years on meth-related legislation, NAMSDL staff has heard repeatedly that our organization's services were valued

because NAMSDL provides a central source of what other states have done legislatively and information – anecdotal and quantitative as provided by states – re: shortcomings and successes of a variety of legislative efforts. These state officials have frequently expressed the frustration of the lack of national data related to methamphetamine, particularly the costs to states of meth and its related issues which would have been invaluable in their efforts to make need-based arguments to their legislatures. In several cases, states – in the words of one state official – quickly "meat-cleaved" together their best estimates based on figures available to them in order to get an idea of resources lost to this drug and its production as well as resources to be saved by addressing these issues legislatively. States have expressed the need for mechanisms designed to 1) efficiently coordinate available information on meth issues from the agencies, their grantees and state colleagues, 2) organize the data and materials in a cogent manner, 3) identify policy implications of the materials/information and 4) disseminate the information to state legislators and other policymakers in a timely, responsive way so they can use the data/information to make informed decisions. The strategy does not propose to remedy this need for comprehensive, coordinated data at the national level.

With regard to data related to meth laboratories, the strategy necessarily addresses the current shortcomings of the El Paso Intelligence Center, Clandestine Laboratory Seizure System (EPIC's CLSS). To this point, it has not been unusual for NAMSDL staff to receive calls from state officials or Congressional staff – new to working on meth-related issues – asking why there is a significant gap between states' reporting numbers of meth laboratories and EPIC's stats, with the former being a much higher figure. Therefore, the collection process of EPIC does need to be addressed to insure a more accurate assessment of nationwide success in reducing domestic meth labs. However, the strategy places the onus on the states – specifically state and local law enforcement – at a time when their resources are stretched and, per the Administration's proposed "drug budget", their future funding for addressing meth and other drug issues is in jeopardy.

Regional Methamphetamine Legislative and Policy Planning Conferences

Given the unprecedented level of states' legislative efforts to address meth, states have expressed the need for regional planning to prioritize next steps for states and to coordinate initiatives within multistate areas. Therefore, as the strategy briefly mentions, NAMSDL has agreed to partner with ONDCP, OJP/BJA, and the Substance Abuse and Mental Health Services Administration (SAMHSA) to conduct four regional planning events to assist states with their state and regional legislative and policy efforts to address meth and its related issues. Each regional is intended to result in 1) a legislative and policy action plan for each state, 2) identification of laws and policies that are working or having positive benefits for a state that might be worthy of replication in other states in the region, 3) identification of issues, concerns, problems that exist in multiple states, including those that require interstate resolutions, 4) identification of states' needs for federal assistance and federal requests for states' assistance, and 5) identification of issues, concerns, and initiatives that may require collaboration among federal, state and local officials to resolve. In order to accomplish these objectives, NAMSDL will convene regional events that 1) engage a multidisciplinary team of select individuals

from each state and the District of Columbia (D. C.), 2) plenary sessions to inform discussion and planning, and 3) focus on facilitated group processes designed to produce prioritized actions plans. A complete overview of this project has been submitted with my testimony for the record. By having NAMSDL partner to convene these events, these federal agencies appear to recognize that the coordination of priorities and strategies on these issues can improve efficient allocation of resources to accomplish goals and objectives.

The first regional meth legislative and policy planning conference will be held for the South-Southeastern states, July 13-14, 2006 in Birmingham, AL.

State Prescription Drug Monitoring Programs

In the ***Synthetic Drug Control Strategy***, I am encouraged to see the Department of Justice (DOJ), Health and Human Services (HHS), and ONDCP continuing to emphasize addressing the diversion of, misuse of, abuse of and addiction to prescription drugs. The strategy also reflects an acknowledgement and awareness of the need to balance reducing the nonmedical use of prescription drugs with safeguarding the access to controlled substance prescription drugs for licit, medical purposes. Further, it is helpful that these Administration agencies continue to recognize that state prescription drug monitoring programs (PDMPs) can be valuable tools for states in addressing prescription drug diversion, misuse, abuse, and addiction.

As the strategy indicates, a growing number of states are establishing PDMPs and passing enabling legislation to do so. To date, twenty-three states are operating PDMPs and eight states have enacted legislation authorizing them to be established. In NAMSDL's work with states on PDMPs, many have appreciated and benefited from the Administration's emphasis on addressing nonmedical use of prescription drugs and support of state prescription drug monitoring programs. However, the strategy presents the ambitious goal of all 50 states establishing PDMPs before the end of 2008. Given that most states take a minimum of two legislative sessions to pass enabling legislation for these programs, several states have entrenched opposition, and a number of states' legislatures meet every other year, I must caution the subcommittee – as I have my federal colleagues – that this goal may not be realistic.

The strategy emphasizes an important point re: the need to collect data from the administrators of existing PDMPs about the scope of prescription drug problems in their states and the benefits of the PDMP in addressing these issues. As additional states work to assess the need for PDMPs, this outcome data is critical to stakeholders in establishing new state PDMPs.

On a related point, the strategy speaks of sharing "best practices" with states that already have PDMPs and of working with these states to obtain better data about the extent and nature of prescription drug abuse. This information will certainly help those states improve the operation of their existing PDMPs. However, states beginning to consider a PDMP as a viable option for addressing prescription drug addiction, abuse and

diversion also need the collected data and operational information. This would enable states in the PDMP planning stages to avoid "re-inventing the wheel," to take advantage of lessons learned from their state colleagues, and to very likely save resources toward establishing programs. Further, state PDMP administrators have re-asserted that collaborating with officials in neighboring states to establish PDMPs is one of their top priorities. Their overall goal is to ensure all states in their respective regions have these monitoring programs. Therefore, states stand ready and willing to partner in this effort, as they have for many years.

The strategy acknowledges that doctor shopping is "typically for the purpose of feeding an addiction" (p. 33), and that health care providers may use the PDMP information as a tool for early identification. For a state PDMP to be effectively used as such an early identification tool, health professionals need to understand where to turn for assessment and treatment assistance. Therefore, I hoped the strategy would include an emphasis on assisting state PDMPs and the health professionals (who may be authorized to access state PDMP data) to connect with addiction treatment resources, particularly through the education of physicians and other health professionals about the availability of options for assessment and referral to addiction treatment in their states.

I would also have liked the strategy to commit to assisting states to develop efficient, coordinated technical and legal procedures for sharing information among states PDMPs to address interstate diversion and nonmedical use. Interstate sharing of this kind is a priority among current state PDMP officials and point of concern among members of Congress working to address these issues.

Additional Federal Assistance Needed by States to Address Nonmedical Use of Prescription Drugs

The Internet remains a concern for states in addressing prescription drug diversion, misuse, abuse, and addiction. Therefore, I am encouraged that this will remain an Administration priority per the strategy. Points of access about which states are concerned that are unaddressed in the strategy are military hospitals, Veterans Administration hospitals, and tribal lands. Pharmacies in or on these entities may not be bound by state law and thus may not be required to report to state PDMPs. However, officials from states in which these entities have a significant presence believe that these dispensaries present opportunities for diversion, abuse, and misuse and it would benefit states to have them report to these programs. States continue to ask for federal assistance to address this gap.

Another need is for proactive educational initiatives, developed in conjunction with state PDMP officials, to provide useful PDMP information to decision makers in states who are beginning to address the problem of prescription drug addiction, abuse and diversion. This information would include, but not be limited to: the benefits of PDMPs, information to health professionals and law enforcement in undertaking their professional responsibilities within the PDMP, and potential cost savings to a state of a PDMP.

Input from, Coordination with the States to Address Synthetic Drugs

I was encouraged by the strategy's acknowledgement of states' initiative, leadership, and success in address synthetic drug issues. However, the strategy does not include a description of how states' input will be solicited and incorporated through an ongoing mechanism to ensure that the gap between federal action and states' needs does not continue or redevelop. Instead, the document takes the "top down" approach of the federal agencies administering to states, which is disappointing given the high level of state action and expertise in this arena.

The Administration agencies involved in this strategy tout and encourage state drug control strategies. The document contends that some states have drug control strategies while most do not. If the agencies believe this to be the case, what initiatives will they undertake moving forward which differ from those taken in past years to better influence states to develop coordinated strategies? How will they determine which states do not have these plans? These types of intended action steps are not outlined in the strategy toward the stated goal of increasing the number of states with drug control strategies.

Concluding Remarks

Congressman Souder and Ranking Member Cummings, I want to add that in NAMSDL's ongoing work with states, our contacts consistently recognize the leadership that Congress has shown in addressing methamphetamine and in retaining much needed federal dollars for state and local efforts to address alcohol and other drug issues. Specifically, they often reference this subcommittee and its attention to these critical issues. I extend their thanks and praise to you and your colleagues.

I also want to commend our national partners on this panel *(listing current as this testimony goes to print)*: National Narcotic Officers' Associations' Coalition (NNOAC), Community Anti-Drug Coalitions of America (CADCA), National Association of State Alcohol/Drug Abuse Directors (NASADAD), and the National Association of Counties (NACo). Their constituents and members are many of the leaders at the state and local levels that I reference in my testimony. I am grateful for their collective work.

Thank you once again for the opportunity to share this information with you. I would be happy to answer any questions that you have as the hearing proceeds.